SOUTHEASTERN SPINE CENTER & RESEARCH INSTITUTE – PATIENT HEALTH HISTORY

Please complete the following questionnaire. It is designed to assist our providers with your care and better understand your medical information. **Please answer every section**.

Patient Name: _____ D.O.B.: _____ SS#_____

Medications: ☐ None ☐ See Attached List

DRUG	DOSAGE	HOW OFTEN TAKEN	REASON FOR TAKING MEDICATION

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

11._____

12._____

13._____

14._____

15._____

BLOOD THINNERS: _____

Allergies: ☐ None Known ☐ Penicillin ☐ Aspirin ☐ Sulfa ☐ Other _____

Reaction: _____

Patient Signature:_____ **Date**: _____

Provider Signature:_____ **Date**: _____